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CHAPTER V

BILLING INSTRUCTIONS

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## CHAPTER V

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## CHAPTER V BILLING INSTRUCTIONS

### GENERAL INFORMATION

This chapter describes the procedures necessary to obtain payment from the Virginia Medicaid Program for services provided to eligible Medicaid recipients. Included in this chapter are instructions for completing the HCFA-1500 (12-90) claim form as a billing invoice, an adjustment invoice, and a void invoice. The provider must complete the invoice and submit it to the Fiscal Agent.

#### Timely Filing

Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid may make payment for services rendered more than 12 months before the claim is submitted when the claims are for a recipient who has been determined retroactively eligible for Medicaid. Applicants will be found eligible for Medicaid for up to three months prior to the month of application if the recipient was eligible during this period of time. If the individual received Medicaid-covered services during the retroactive period, Medicaid will accept and process the claim.

When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he or she has 12 months from the date of notification of the Medicaid eligibility in which to file the claim. Providers who have rendered care or services during this retroactive period are notified by a letter from the local social services department.

The provider may submit a claim which is more than 12 months from the date of service but is not more than 12 months from the date of the notification of the retroactive eligibility. A copy of the letter from the Department of Social Services indicating the date of notification of the retroactive eligibility must be attached to the claim.

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- Preauthorized Services For Retroactive Eligibility - For services requiring preauthorization, all preauthorization criteria must be met for the claim to be paid. For those services occurring in a retroactive eligibility period, after-the-fact authorizations will be performed by DMAS.
- Rejected or Denied Claims - Rejected or denied claims which have been submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:
  - Complete the invoice as explained under the Instructions for Completion of the HCFA-1500 (12-90) elsewhere in this chapter.
  - Explain the reason for the late submission in the Remarks section of the invoice and attach written documentation to verify the explanation. This documentation may be photocopies of invoices or denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period.
  - Submit the claim in the usual manner using the preprinted envelopes supplied by Medicaid or by mailing the claim to:

DMAS-Transportation  
P. O. Box 27447  
Richmond, Virginia 23261-7447

The first copy of a multicopy invoice form must be submitted in the preaddressed Medicaid envelope. The additional copy is retained by the provider for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

- Exceptions - The state Medicaid agency is required to adjudicate all claims within 12 months of receipt, except in the following circumstances:
  - The claim is a retroactive adjustment paid to a provider who is reimbursed under a retrospective payment system.
  - The claim is related to a Medicare claim which has been filed in a timely manner, and the Medicaid claim is filed within six months of the

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disposition of the Medicare claim.

- This provision applies when Medicaid has suspended payment to the provider during an investigation and the investigation exonerates the provider.
- The payment is in accordance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

The procedures for the submission of these claims are the same as previously outlined. The required documentation must be written confirmation that the reason for the delay meets one of these specified criteria.

- Accident Cases - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.

### Electronic Billing

Transportation providers may submit claims electronically via tape, diskette, or dial-up to the DMAS fiscal agent, First Health Services Corporation, for transportation services provided to Medicaid recipients. This service is a systems enhancement that is available to providers of transportation services. Providers may continue to submit paper claims on the HCFA-1500 (12-90) claim form if they choose to do so.

Call the EDI Coordinator at First Health Services Corporation (804) 273-6779 to obtain the *Electronic Billing Specifications Manual* for electronic billing. Once the provider has obtained the billing specifications, he or she will be required to submit a test batch of claims electronically before he or she can begin submitting claims in production.

The *Electronic Billing Specifications Manual* contains important information and explains how to submit the Verification of Non-Emergency Transportation form (DMAS-9) electronically. It is very important that providers follow the special instructions or their claims will be rejected by the system for reject reason 050, "Transportation Verification Form Not Attached."

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DMAS requires completion of the Verification of Non-Emergency Transportation form, and the provider must maintain it for verification by DMAS staff upon request.

Direct questions regarding the specifications to the EDI Coordinator at First Health Services at the number listed above. Direct questions concerning billing to the Medicaid Provider HELPLINE at the numbers listed in Chapter I.

### Requests for Billing Materials

Laser-printed copies of the HCFA-1500 (12-90) will be accepted as long as the back of the claim is printed.

The requirement to submit claims on an original HCFA-1500 (12-90) or two-sided laser printed form is necessary because the individual signing the invoice is attesting to the statements on the reverse side, and, therefore, these statements become part of the original billing invoice.

DMAS will not supply the HCFA-1500 (12-90) billing forms. DMAS will supply the mailing envelopes for the provider's use. Use the "Request for Billing Supplies" form (DMAS-160) to order envelopes. (See "EXHIBITS" at the end of this chapter for a sample of this form.) Check the DMAS-666 block to order envelopes and the DMAS-9 block to order the Verification Form. Send the "Request for Billing Supplies" to:

DMAS Order Desk  
North American Marketing  
3703 Carolina Avenue  
Richmond, Virginia 23222

Send all requests for information or questions concerning the ordering of forms to the address above, or call 804-329-4400.

Providers may purchase HCFA-1500 (12-90) forms from commercial forms printers or suppliers or from the US Government Printing Office. Providers may find a forms printer or supplier under a listing such as Business Forms and Systems in a Yellow Pages or other directory. Providers may contact the US Government Printing Office at:

US Government Printing Office  
Superintendent of Documents  
Washington DC 20402

### Billing Address

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When the claim form is completed, Transportation providers must return the invoice to:

DMAS-Transportation  
P. O. Box 27447  
Richmond, Virginia 23261-7447

## **BILLING INSTRUCTIONS**

DMAS requires claims for transportation services to be submitted on the HCFA-1500 (12-90) claim form. The instructions for completing the HCFA-1500 (12-90) as a billing invoice, adjustment invoice, and void invoice are presented below.

Providers must complete each block correctly and completely to receive payment for the services provided and to avoid delays in the processing of the claims. Note that the HCFA-1500 (12-90) must contain claims for only one recipient per claim form. Complete a different claim for each recipient for whom transportation is provided. However, since there are six separate lines per claim form, the provider may bill up to six trips for the same recipient on one HCFA-1500 (12-90). Continue to attach the Verification of Non-Emergency Transportation form (DMAS-9) to the HCFA-1500 (12-90) claim form.

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## INSTRUCTIONS FOR THE USE OF THE HCFA-1500 (12-90) CLAIM FORM

Locator (Block)	Instructions
-----------------	--------------

- |             |   |
|-------------|---|
| <b>1</b>    | <b>Enter an “X” in the MEDICAID box.</b>  |
| <b>1a</b>   | <b>Insured’s ID Number</b> - Enter the 12-digit Virginia Medicaid identification number for the recipient receiving the service. When more than one passenger is transported, enter the number of the person transported the greatest distance. |
| <b>2</b>    | <b>Patient’s Name (Last Name, First Name, Middle Initial)</b> - Enter the name of the recipient for whom transportation was provided.   |
| <b>3</b>    | <b>Patient’s Birth Date</b> - Leave this block blank.   |
| <b>4</b>    | <b>Insured’s Name</b> - Leave this block blank.   |
| <b>5</b>    | <b>Patient’s Address (Pick Up Point)</b> - Enter the complete address of the facility, home, doctor’s office, etc., from which the recipient was transported.   |
| <b>6-23</b> | <b>Leave these blocks blank.</b>  |
| <b>24A</b>  | <b>Date of Service</b> - Enter the date the transportation was provided. Use 6 digits, for example, 01/05/99. Bill for up to 6 different trips to the same destination for the <u>same</u> recipient on one HCFA-1500 (12-90) claim form.       |
| <b>24B</b>  | <b>Place of Service</b> - A value of “11” (office) must be used.  |
| <b>24C</b>  | <b>Type of Service</b> - A value of “9” (other medical) must be used.   |
| <b>24D</b>  | <b>Procedures, Services or Supplies</b> - Enter the new 5-digit procedure code in the CPT/HCPCS column which describes the service as follows:  |

Use New

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Locator (Block)                      Instructions

<b><u>Procedure Code</u></b>	<b><u>Description</u></b>
Y0110	Emergency Ambulance
Y0111	Non-Emergency Ambulance One-way trip
Y0112	Non-Emergency Ambulance Round trip
Y0113	Wheelchair Van Mileage, one-way trip
Y0114	Wheelchair Van Mileage, round trip
Y0115	Registered Driver Mileage
Y0118	Taxi Mileage, one-way trip
Y0119	Taxi Mileage, round trip
Y0121	Special Code - <b>Can be used by only authorized providers</b>

**24D**                      **Modifier** - Use a code of “22” and attach information to the claim form when there is additional information that is necessary for Medicaid to process the claim (for example, two separate trips on the same day). **This does not apply to the Verification of Non-Emergency Transportation form. This form must be attached to the invoice for each trip billed on the invoice for non-emergency transportation.**

**24E**                      **Diagnosis Code (Use this block for Wait Time.)** - Enter the number of hours (one digit) of waiting time. Round off to the nearest hour.

**24F**                      **Charges** - Enter the total charges for the trip.

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Locator (Block)                      Instructions

**24G                      Days or Units (Use this block for Miles.)** - Enter the number of miles traveled from the pick-up point of the first passenger to the destination of the last passenger. Round off to the nearest mile. (Example: 10.7 miles must be entered as 11.)

**24H                      EPSDT/Family Planning (Use this block for Number of Passengers.)** - Enter the number of passengers transported. Use one digit only (for example, 3).

**24I                      Leave blank.**

**24J                      COB** - Enter the applicable code:

CODE 2                      To be used when there is no other insurance carrier

CODE 3                      To be used when payment has been received from a private carrier other than Medicare

CODE 5                      To be used to indicate other insurance and that the primary carrier has denied payment. **For ambulance providers, attach the denial from the primary carrier to the claim form and use Modifier “22” in Block 24D, Modifier.**

**24K                      Reserved for Local Use** - Enter the dollar amount, if any, that was paid by the primary insurance carrier. Otherwise, leave blank.

**31                      Signature** - The person completing the invoice must sign and date this block.

**32                      Name and Address of Facility Where Services Were Rendered** - Enter the complete address of the facility, doctor’s office, etc., to which the recipient was transported.

**33                      Transportation Provider Name, Address, and Telephone Number** - Enter the provider’s name, address, and 7-digit provider identification number assigned by Virginia Medicaid (in PIN #). **The provider identification number must be in the field marked PIN #.**

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INSTRUCTIONS FOR THE COMPLETION OF THE HCFA-1500 (12-90) CLAIM  
FORM AS AN ADJUSTMENT INVOICE

The adjustment invoice must be used to make corrections or necessary changes or to request reconsideration of allowances on claims that have been approved for payment. This form is not used for the follow-up of denied, rejected, or pended claims. To adjust (or correct) the original payment, the information must appear on the HCFA-1500 (12-90) as the original claim **should have appeared**. To complete the HCFA-1500 (12-90) as an adjustment invoice, follow the same instructions as for the original invoice with the addition of the block indicated below:

Block 22

**Medicaid Resubmission**

Code - Enter the 3-digit code identifying the reason for the submission of the adjustment:

- 523 Primary carrier has made additional payment
- 524 Primary carrier has denied payment
- 527 Correcting service date
- 528 Correcting procedure/service code
- 530 Correcting charges
- 531 Correcting miles

**Original Reference Number** - Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. **Only one claim can be adjusted on each HCFA-1500 (12-90) submitted as an Adjustment Invoice.**

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**INSTRUCTIONS FOR THE COMPLETION OF THE HCFA-1500 (12-90) CLAIM  
FORM AS A VOID INVOICE**

The void invoice must be used to void a paid claim. This form is not used for the follow-up of denied, rejected, or pended claims. To void the original payment, the information must be identical to the original invoice with the addition of the block indicated below:

Block 22

**Medicaid Resubmission**

Code - Enter the 3-digit code identifying the reason for the submission of the void:

- 544 Wrong provider ID #
- 545 Wrong recipient ID #
- 547 Duplicate payment was made
- 560 Other insurance is available

**Original Reference Number** - Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. **Only one claim can be voided on each HCFA-1500 submitted as a Void Invoice.**

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## **INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE**

Virginia Medicaid purchases Medicare Part B coverage for all Medicaid recipients eligible for Medicare benefits and makes payment to providers for Medicare coinsurance and deductible.

The Medicare Program Part B Carriers serving Virginia and the Virginia Medicaid Program have developed a system whereby these carriers will send to Virginia Medicaid the Medicare Explanation of Benefits (EOB) for identified Virginia recipients. This information will be used by the Program to pay Medicare coinsurance and deductible amounts as determined by the carrier. Do not bill Virginia Medicaid directly for services rendered to Medicaid recipients who are also covered by Medicare Program Part B carriers serving Virginia. However, the DMAS-31 adjustment form may be used when needed.

If the Medicare Part B carrier is one of these, bill Medicare directly on the appropriate invoice.

Upon receipt of the Medicare EOB, Virginia Medicaid will process payment automatically to participating providers when the recipient's Medicare number and the provider's Medicare vendor/provider number are in the Medicaid files. Those providers billing Medicare under more than one Medicare vendor/provider number must identify these numbers and names to the Medicaid Program to update its files. Medicare vendor/provider number additions or deletions must also be sent to the Program.

This automatic payment procedure includes Medicaid recipients with Railroad Retirement Medicare benefits.

If problems are encountered, the DMAS-30 invoice form should be completed, and a copy of the EOB attached and forwarded to:

Practitioner  
Department of Medical Assistance Services  
P. O. Box 27444  
Richmond, Virginia 23261-7444

NOTE: Medicaid eligibility is reaffirmed each month for most recipients. Therefore, bills must be for services provided during each calendar month, e.g., 01-01-99 - 01-31-99.

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Instructions for the Completion of the Department of Medical Assistance Services  
(Title XVIII) Medicare Deductible and Coinsurance Invoice, DMAS-30 (Revised 1/91)

**Purpose** To provide a method of billing Medicaid for Medicare deductible and coinsurance. (See "EXHIBITS" at the end of this chapter for a sample of this form.)

**Explanation**

Block 1 **Transmission Code** - This is a number assigned and preprinted by the Department of Medical Assistance Services.

Block 2 **Provider Identification Number** - Enter the 7-digit provider identification number assigned by Medicaid and the provider name and address.

Block 3 **Recipient's Name** - Enter the last name and the first name of the patient as they appear on the recipient's eligibility card.

Block 4 **Recipient Identification Number** - Enter the 12-digit number appearing on the recipient's eligibility card.

Block 5 **Patient Account Number** - If a numbering system is used by the provider for patient identification, enter the patient's number in this block. This number will appear on the Remittance Voucher preceding the name. If no such system is used, leave this block blank.

Block 6 **Recipient HIB Number (Medicare)** - Enter the recipient's Medicare number.

Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation.)

**Code 2 - No Other Coverage** - If the Carrier Code on the recipient's Medicaid eligibility card is blank, indicating no other coverage or contains the code 001 (Medicare), check Block 2.

**Code 3 - Billed and Paid** - When a recipient has other coverage

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that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 12. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.

**Code 5 - Billed and No Coverage** - If the recipient has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 8      **Type Coverage (Medicare)** - Mark type of coverage "B."

Block 9      **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.

Block 9A      **Place of Treatment** - The code entered here should be the same codes used to submit claims to Medicare. Without these codes, the claims could process incorrectly resulting in the calculation of an incorrect copay amount(s). Enter the appropriate code:

41                      Ambulance—Land  
42                      Ambulance, Air or Water

Block 10      **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:

Accident -      Possible third-party recovery  
Emergency -      Not an accident  
Other -              If none of the above

Block 11      **Type of Service** - The code entered here should be the same code used to submit claims to Medicare. Without this code, the claims could process incorrectly resulting in the calculation of an incorrect copay amount(s). Enter Code D Ambulance.

Block 11A      **Procedure Code** - Enter the 5-digit HCPCS/CPT-4 code which was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank.

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Block 11B      **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare.

Block 12      **Date of Admission** - Leave blank.

Block 13      **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (through), e.g., 01-09-99 to 09-30-99.

Block 14      **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15      **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16      **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOB).

Block 17      **Deductible** - Enter the amount of the deductible (taken from the Medicare EOB).

Block 18      **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOB).

Block 19      **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments.)

Block 20      **Patient Pay Amount, LTC Only** - Leave blank.

**Signature**      The signature of the provider or the agent and the date signed are required.

**Mechanics  
and  
Disposition**

Information as explained above may either be typed or legibly handwritten. If an explanation regarding this claim is necessary, the "Remarks" section must be used. Separate the original copy and attach a copy of the EOB. Retain the provider's copy in the office

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files. Send the completed claim and the attachment in the envelope supplied by the Program to:

Transportation  
Department of Medical Assistance Services  
P. O. Box 27447  
Richmond, Virginia 23261-7444

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Instructions for the Completion of the Department of Medical Assistance Services  
(Title XVIII) Medicare Deductible and Coinsurance Adjustment Invoice, DMAS-31  
(Revised 1/91)

<b>Purpose</b>	To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied, rejected, or pended claims. (See "EXHIBITS" at the end of this chapter for a sample of this form.)
<b>Explanation</b>	To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.
Block 1	<b>Adjustment/ Void</b> - Check the appropriate block.
Block 2	<b>Provider Identification Number</b> - Enter the 7-digit provider identification number assigned by Medicaid which will be used for processing.
Block 2A	<b>Reference Number</b> - Enter the reference number taken from the Title XVIII Deductible and Coinsurance Remittance Voucher for the line of payment needing adjustment. The reference number (nine digits) follows the recipient's eligibility number on the remittance voucher. The adjustment cannot be made without this number since it identifies the original invoice.
Block 2B	<b>Reason</b> - Leave blank.
Block 2C	<b>Input Code</b> - Leave blank.
Blocks 3-20	Refer to the instructions for the completion of the DMAS-30 for the completion of these blocks.
<b>Remarks</b>	Use this section of the invoice to give a brief explanation of the change needed.
<b>Signature</b>	The signature of the provider or the authorized agent and the date signed are required.

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**Mechanics  
and  
Disposition**

The form may either be typed or legibly handwritten. Separate and forward the intermediary copy in the preaddressed envelope supplied by the Program. Retain the provider's copy in the office files.

The correct address is:

Transportation  
Department of Medical Assistance Services  
P. O. Box 27444  
Richmond, Virginia 23261-7444

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## **REMITTANCE VOUCHER**

### General Information

DMAS sends a remittance voucher with each payment. This voucher is a listing of approved, pended, denied, adjusted, or voided claims and must be kept in a permanent file for five years.

The check is the last item in the envelope. The remittance voucher includes an address sheet which has been added for security purposes. The address sheet contains the provider's name and address. The remittance voucher contains a space for special messages from DMAS.

Participating providers are encouraged to monitor the remittance vouchers for special messages that will expedite notification on matters of concern. This mechanism may be used to alert providers on matters that may relate to:

- Pending implementation of policies and procedures
- Sharing clarification on a concern expressed by a provider

## **CLAIM INQUIRIES**

Inquiries concerning covered benefits, specific billing procedures, or remittances must be directed to:

Provider Inquiry Unit/Transportation  
Division of Client Services  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

## **TRANSPORTATION HELPLINE**

The Medicaid Transportation HELPLINE answers questions concerning billing problems, covered transportation, and payments. The Medicaid Transportation HELPLINE telephone number is:

1-800-358-5050

All areas

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The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays.

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**EXHIBITS**

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES  
REQUEST FOR BILLING SUPPLIES

Name \_\_\_\_\_ Date \_\_\_\_\_

Provider Number \_\_\_\_\_ Contact Person \_\_\_\_\_

Telephone # (\_\_\_\_\_) \_\_\_\_\_  
(Area Code)

Check As Appropriate

- \_\_\_\_\_ Please forward preprinted invoices as indicated below.  
\_\_\_\_\_ Please forward invoices suitable for computer use as indicated below.  
\_\_\_\_\_ Other (See Order Below)

Quantity:    Dental:  
\_\_\_\_\_ DMAS-701 Invoice  
\_\_\_\_\_ DMAS-702 Invoice Adjustment  
\_\_\_\_\_ DMAS-704 Preauthorization Req  
\_\_\_\_\_ DMAS-703 Envelope

\_\_\_\_\_ Home Health Agency:  
\_\_\_\_\_ DMAS-662 Envelope

\_\_\_\_\_ Hospital:  
\_\_\_\_\_ DMAS-660 Envelope

\_\_\_\_\_ Laboratory:  
\_\_\_\_\_ DMAS-123 Invoice  
\_\_\_\_\_ DMAS-230 Invoice Adjustment  
\_\_\_\_\_ DMAS-665 Envelope

\_\_\_\_\_ Nursing Home:  
\_\_\_\_\_ DMAS-215 Invoice  
\_\_\_\_\_ DMAS-262 Invoice Adjustment  
\_\_\_\_\_ DMAS-661 Envelope

\_\_\_\_\_ Personal Care: NOT PREPRINTED  
\_\_\_\_\_ DMAS-93 Invoice  
\_\_\_\_\_ DMAS-94 Invoice Adjustment  
\_\_\_\_\_ DMAS-659 Envelope

Quantity:    Pharmacy:  
\_\_\_\_\_ DMAS-173 Drug Claim Ledger  
\_\_\_\_\_ DMAS-228 Drug Claim Adjustment  
\_\_\_\_\_ DMAS-664 Envelope

\_\_\_\_\_ Practitioner:  
\_\_\_\_\_ DMAS-663 Envelope

\_\_\_\_\_ Special Service: NOT PREPRINTED  
\_\_\_\_\_ DMAS-199 Invoice  
\_\_\_\_\_ DMAS-233 Invoice Adjustment  
\_\_\_\_\_ DMAS-666 Envelope

\_\_\_\_\_ Title XVIII: NOT PREPRINTED  
\_\_\_\_\_ DMAS-30 (Medicare) Deductible  
\_\_\_\_\_ and Coinsurance Invoice  
\_\_\_\_\_ DMAS-31 Invoice Adjustment

\_\_\_\_\_ Transportation: NOT PREPRINTED  
\_\_\_\_\_ DMAS-7 Invoice  
\_\_\_\_\_ DMAS-8 Invoice Adjustment  
\_\_\_\_\_ DMAS-666 Envelope  
\_\_\_\_\_ DMAS-9 Verification Form

Please return this form to: DMAS Order Desk  
North American Marketing  
3703 Carolina Avenue  
Richmond, Virginia 23222

DMAS-160 R 3/94

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

APPROVED OMB-0938-0028

CARRIER

PICA

### HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		CHAMPUS <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (VA File #)		GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)		FECA BLK LUNG <input type="checkbox"/> (SSN)		OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)								3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)								6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED													
14. DATE OF CURRENT: MM DD YY				ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE								17a. I.D. NUMBER OF REFERRING PHYSICIAN				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE								20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____								23. PRIOR AUTHORIZATION NUMBER													
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY		B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPSTD Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		PIN#		GRP#	

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)  
FORM OWCP-1500 FORM RRB-1500

## TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

## VIRGINIA

## DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

091

1 TRANSMISSION CODE		2 PROVIDER I.D. NO.(7)											
3 RECIPIENT'S LAST NAME			FIRST NAME		4 RECIPIENT I.D. NUMBER (12)	5 PATIENT ACCOUNT NUMBER	6 RECIPIENT'S HIB NUMBER (MEDICARE)						
7 PRIMARY CARRIER INFORMATION OTHER THAN (MEDICARE) <input type="checkbox"/> 2 NO OTHER COVERAGE <input type="checkbox"/> 3 BILLED AND PAID <input type="checkbox"/> 5 BILLED NO COVERAGE			8 TYPE COVERAGE (MEDICARE) <input type="checkbox"/> A <input type="checkbox"/> B	9 DIAGNOSIS	9A PLACE OF TREAT (2)	10 ACCIDENT/EMERGENCY INDICATOR <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> E <input type="checkbox"/> M <input type="checkbox"/> O <input type="checkbox"/> T <input type="checkbox"/> H <input type="checkbox"/> E <input type="checkbox"/> R	11 TYPE SERV (1-2)	11A PROCEDURE CODE (5)	11B VISITS/UNITS STUDIES (3)	12 DATE OF ADMISSION MO (2) DAY (2) YEAR (2)	13 STATEMENT COVERS PERIOD FROM MO (2) DAY (2) YEAR (2) THRU MO (2) DAY (2) YEAR (2)		
14 CHARGES TO MEDICARE		15 ALLOWED BY MEDICARE		16 PAID BY MEDICARE		17 DEDUCTIBLE		18 COINSURANCE		19 PAY BY CARRIER OTHER THAN MEDICARE		20 PATIENT PAY AMOUNT LTC ONLY	

  

3 RECIPIENT'S LAST NAME		FIRST NAME		4 RECIPIENT I.D. NUMBER (12)		5 PATIENT ACCOUNT NUMBER		6 RECIPIENT'S HIB NUMBER (MEDICARE)					
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REMARKS: IDENTIFY LINE ITEM TO WHICH REMARKS REFER

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

ORIGINAL COPY

SIGNATURE

DATE

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE  
**VIRGINIA**

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

1 ADJUSTMENT <input type="checkbox"/> 092		VOID <input type="checkbox"/> 094		2 PROVIDER I.D. NO. (7)		A REFERENCE NUMBER (9)		B REASON		C INPUT CODE											
3 RECIPIENT'S LAST NAME			FIRST NAME			4 RECIPIENT'S I.D. NUMBER (12)			5 PATIENT ACCOUNT NUMBER			6 RECIPIENT'S HIB NUMBER (MEDICARE)									
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\_\_\_\_\_ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

ADJUSTMENT

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